

Voluntary Contributions Election

Before you make your election, please read all of the information in the Voluntary Contributions Notice (RI 38-125) and the Special Tax Notice Regarding Rollovers (RI 37-22). For more information about Voluntary Contributions or this election, call 1-888-828-9451.

Please print clearly when you provide the following information:

Your name (<i>last, first, middle</i>)	Date of birth (<i>mm/dd/yyyy</i>)
Your address -----	Daytime telephone number (<i>including area code</i>)
Your Voluntary Contributions Account Number VC	Your Social Security Number

Date of Retirement or Separation (*if applicable*) _____

To receive a refund, please send this form to the Office of Personnel Management, Retirement Operations Center, PO Box 45, Boyers, PA 16017-0045, Attn: Refunds Section. If you are retiring, send this form at least 60 days before your separation date. If you are making payments via Pre-Authorized Debit (PAD), you should contact your financial institution to have the debits discontinued. To purchase additional annuity, return this form to your personnel office with your application for retirement.

1. Additional Annuity

☐ I want to use my voluntary contributions (VC) to purchase additional annuity.

✓ Please check one of the following options.

☐ I do not want to provide a VC survivor annuity. ☐ I want to provide a VC survivor annuity for the person named below.

Name of person (<i>last, first, middle</i>)	His/Her date of birth
His/Her address -----	

His/Her Social Security Number	His/Her relationship to you, if any
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Warning: Any intentionally false or willfully misleading response you provide in this election is a violation of the law and punishable

Signature	Date (<i>mm/dd/yyyy</i>)
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2. Send Me Additional Information After I Retire

☐ I do not want to make an election at this time. I want the Office of Personnel Management (OPM) to send me information that is specific to my case. I understand this information will be sent after OPM receives my application for retirement.

Signature	Date (<i>mm/dd/yyyy</i>)
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(continued on the reverse)

3. Refund of Voluntary Contributions

The principle amount in the Voluntary Contributions account will be mailed to you at the address you provided on this election form. Also, you can elect to receive a refund of the interest or elect to roll over all or part of the interest.

✓ Please check one of the following options.

☐ Pay my refund on the date I separate for retirement.

☐ Pay my refund as soon as possible.

✓ Please check one of the following options.

☐ I want to receive a refund of my Voluntary Contributions, plus interest. I understand that the interest will be subject to a 20% income tax withholding if it is more than \$200. To defer taxes I can roll the interest over within 60 days to an IRA account (or other qualified employer retirement plan) and apply for any excess tax withholding when I file my Federal income tax return.

☐ I want _____ (enter "all", or a dollar amount at or above \$500) of the interest rolled over and made payable to the account shown in Part 4, with no tax withholding on the amount rolled over. I understand that any balance of the interest paid to me will be subject to 20% tax withholding. To defer taxes I can roll the interest over within 60 days to an IRA account (or other qualified employer retirement plan) and apply for any excess tax withholding when I file my Federal income tax return.

✓ If you elected to roll the interest over, please check one of the following options.

☐ Send the interest payment directly to the account shown in Part 4.

☐ Send the interest payment to me, made payable to my account. I will deliver it to the account within 60 days.

Signature

Date (mm/dd/yyyy)

4. Certification by Financial Institution or Retirement Plan

Name of institution or retirement plan

IRA account number

Address of institution or retirement plan


Certification: As a representative of the financial institution or plan named above, I confirm the account number for the individual named above and the address of the institution or retirement plan. I certify that the financial institution or plan named above agrees to receive funds from the individual and deposit them in an eligible IRA or retirement plan as defined in the Internal Revenue Code.

Typed or printed name of certifying representative

Signature of certifying representative

Telephone number (including area code)

Date of certification (mm/dd/yyyy)

Office of Federal Employees' Group Life Insurance 200 Park Avenue New York, NY 10166-0188		Statement of Claim Option C—Family Life Insurance Federal Employees' Group Life Insurance	Read instructions on the reverse side of this form before completing form.
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Part A—General Information About the Insured

1. Name of Insured (<i>Employee or Annuitant</i>) (<i>Last, first, middle</i>)	2. Date of birth (<i>mm/dd/yyyy</i>)	3. Social Security Number
4. Department or agency in which employed (include bureau or division)	5. Location of employment (<i>City, State, Zip Code</i>)	
6. Are you retired and receiving annuity under any Federal civilian retirement system?		
<input type="checkbox"/> Yes, Give _____ <input type="checkbox"/> No	6a. Retirement claim number	6b. Date of retirement

Part B—Information About Deceased Family Member

1. Full name of deceased	2. Date of birth (<i>mm/dd/yyyy</i>)	3. Date of death (<i>mm/dd/yyyy</i>)
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Complete blanks 4-7 if deceased is your SPOUSE

4. Date of marriage (<i>mm/dd/yyyy</i>)	5. Place of marriage (<i>City, State</i>)	6. Marriage was performed by <input type="checkbox"/> Clergy or Justice of the Peace <input type="checkbox"/> Other (<i>Specify</i>)
7. Was this marriage ended by divorce?		
<input type="checkbox"/> Yes, Give _____ <input type="checkbox"/> No	7a. Date of divorce (<i>mm/dd/yyyy</i>)	7b. Place of divorce (<i>City, State</i>)

Complete blanks 8-11 if deceased is your CHILD

8. Child's marital status <input type="checkbox"/> Single <input type="checkbox"/> Married	9. Child's relationship to you <input type="checkbox"/> Legitimate child <input type="checkbox"/> Adopted child <input type="checkbox"/> Stepchild <input type="checkbox"/> Recognized natural child	<input type="checkbox"/> Foster child <input type="checkbox"/> Disabled dependent child 22 yrs. or over <input type="checkbox"/> Other (<i>Specify</i>)
10. If the deceased was a stepchild, recognized natural child, or foster child, was the child living with you at the time of death? <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>Explain on separate sheet</i>)		11. If the deceased was a recognized natural child and was not living with you at the time of death, did you provide financial support for the child? <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>Explain on separate sheet</i>)

Part C—Certification By the Insured

1. Backup Withholding Has the IRS notified you that you are subject to backup withholding as a result of a failure to report all interest or dividends? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. Signature of insured (<i>Do not print</i>)	
I hereby certify that all statements made in this claim are true to the best of my knowledge, information, and belief, and that no evidence necessary to a settlement of this claim is suppressed or withheld.	3. Full name of insured (<i>Type or print</i>)	
	4. Mailing address (<i>Number, street, apt. no.</i>)	
	5. City, State and Zip code	
Warning —Any materially false, fictitious or fraudulent statement or representation which is knowingly and willfully made or any concealment of a material fact which is related to the requests for information required herein is punishable under 18 U.S.C. Statute 1001 by a monetary fine or imprisonment for not more than five years, or both.	6. Date (<i>mm/dd/yyyy</i>)	7. Telephone number (<i>incl. area code</i>)

Part D—Certification of Insurance Status

ACTIVE Employees — Employing agency must complete. FORMER Employees who are RETIREES or COMPENSATIONERS — Office of Personnel Management must complete.		
1a. Did the insured have Option C on the date of death of the family member? Yes <input type="checkbox"/> No <input type="checkbox"/>	1b. Effective date of election	I certify that the information I gave in Part D is correct and that I obtained it from the employee's/annuitant's official records.
2a. Number of multiples: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		4. Signature of authorized agency official
2b. If the insured indicated in Item 9 of Part B that the deceased was a foster child or disabled dependent child, do you certify that the child qualifies for Option C coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>		5. Name of authorized agency official (<i>Type or print</i>)
3a. If the insured is retired or receiving compensation, complete Boxes 3b, 3c and 3d below.		6. Title
3b. Date of retirement or receipt of compensation (<i>mm/dd/yyyy</i>)		7. Name of agency
3c. Date of birth (<i>mm/dd/yyyy</i>)		8. Mailing address of agency, including ZIP Code
3d. Option C election Number of Multiples for Full Reduction: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Number of Multiples for No Reduction: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		9. Telephone number () —
		10. Date signed (<i>mm/dd/yyyy</i>)

Instructions

1. To Avoid Delay

- (a) Read these instructions carefully.
- (b) Type or print in ink.

2. Completion of Claim

Complete parts A, B and C.

3. Evidence Required

You must submit a certified death certificate showing the cause and manner of death with this claim (a photocopy is not acceptable). You may obtain this record from the Bureau of Vital Statistics or equivalent agency. Failure to submit a certified death certificate will delay settlement of this claim. We may need additional evidence and will let you know.

4. If You Need Assistance

If you need assistance in completing this claim, contact your employing office if you are an employee or the Office of Personnel Management if you are a retiree or compensationner.

If you need further assistance, you may write the Office of Federal Employees' Group Life Insurance, 200 Park Avenue, New York, NY 10166-0188 or call the OFEGLI Service Representative, toll-free, at 1-800-OFE-GLIA (1-800-633-4542).

5. Where to Send Claim

If you are an active employee, send the completed claim form and the certified death certificate to your employing office. If you are retired or receiving Federal Workers' Compensation benefits, send the completed claim form and the certified death certificate to: Office of Personnel Management,

Retirement Operations Center, Attention: FE-6 DEP
Boyers, PA 16017.

Your employing office or OPM will verify your family insurance status and forward the certified claim and death certificate to the Office of Federal Employees' Group Life Insurance for payment or further action.

**DO NOT SEND YOUR CLAIM DIRECTLY
TO OFEGLI**

6. To Cancel Option C

If you no longer have any eligible family members you may wish to cancel your Option C coverage.

Active Employees - Contact your employing office.

Retirees or Compensationners - Write:

Office of Personnel Management
Retirement Operations Center,
Attention: Annuity Adjustment Section
Boyers, PA 16017

Be sure to include your retirement or compensation claim number.

Instructions to Agency/Retirement System

When you receive a claim form and certified death certificate from an employee or annuitant, complete Part D of the claim form. You are responsible for determining eligibility for foster children and disabled children age 22 and over. See the definitions below. Do not send the background documentation to OFEGLI. Simply indicate your certification in Part D of the claim form.

After you complete Part D, mail the form and death certificate to the Office of Federal Employees' Group Life Insurance, 200 Park Avenue, New York, NY 10166-0188.

Definition of Terms

Disabled dependent child 22 yrs. or over means a child who was incapable of self-support because of a mental or physical disability that existed before the child became 22 years of age.

Foster child means a child living with you in a regular parent-child relationship where you are the primary source of financial support for the child and expect to raise the child to adulthood. A child placed in your home by a welfare or social service agency under an agreement where the agency retains control of the child or pays for maintenance does not qualify as a foster child. Grandchildren, as such, are not eligible family members. However, grandchildren can qualify as foster children if they meet all of the requirements.

Recognized natural child means a child born out of wedlock whom you recognized as your child during the child's lifetime. In addition, at the time of the child's death, he/she must have either lived with you in a regular parent-child relationship or been dependent on you financially.

Regular parent-child relationship means that you exercise parental authority, responsibility, and control over the child by caring for, supporting, disciplining, and guiding the child, including making decisions about the child's education and health care.

IF YOU HAVE ANY QUESTIONS CONCERNING YOUR CHILD'S ELIGIBILITY FOR COVERAGE, YOU MUST CONTACT YOUR EMPLOYING AGENCY OR RETIREMENT SYSTEM, AND NOT OFEGLI.

PRIVACY ACT STATEMENT

"Privacy Act Notice. We are authorized to request this information under 5 U.S.C. Chapter 84. Executive Order 9397 authorizes us to ask for your Social Security number, which will be used to identify your account. You are not required by law to provide this information, but if you do not provide it, it may not be possible to process the actions you request on this Web site."